Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: SURGERY CENTER OF DUNCANVILLE 1018 E. WHEATLAND ROAD DUNCANVILLE TX 75116	MFDR Tracking #: M4-08-1193-01 DWC Injur
Respondent Name and Box #: TPCIGA FOR RELIANCE NATIONAL Box #: 50	Date Empl Insur

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL D

Requestor's Position Summary as stated on the Table of Disputed Services: "Pymt is not included in allowance."

Principal Documentation:

1. DWC 60 Package
2. Medical Bills
3. EOBs
4. Medical Documentation
5. Total Amount Sought - $11,191.20

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "...We have no evidence the provider requested reconsideration for the above date of service as required by DWC rule 133.250. In addition, there is no evidence the provider submitted a signed certification statement regarding implants, rebates, discounts as required by DWC rule 134.402(f)..."

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

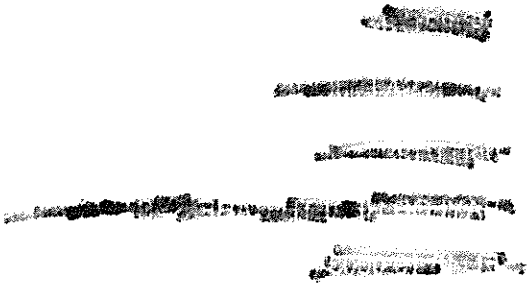
Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
06/11/07	L8680 x 2, L8689, L8681, E1399	N/A	$11,191.20	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §134.402, sets out the fee guidelines for the reimbursement of services provided in an Ambulatory Surgical Center or after March 10, 2005.
4. 28 Tex. Admin. Code §134.1, sets out the guidelines for medical reimbursements.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:



Explanation of benefits dated July 26, 2007

- 97 – Pymt is included in the allowance for another serviceserviced/proc. The service listed under this PX code are included in a more comp code which accurately describes the entire PX(S) performed.

Issues

1. Did the Requestor certify the implant invoice?
2. Is the requestor entitled to reimbursement?
3. Did the Requestor apply fair and reasonable reimbursement to non-valued codes?

Findings

1. According to 28 TAC Section 134.402(e)(4) the carrier shall reimburse all surgically implanted, inserted, or otherwise applied devices at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) actually paid for such device to the manufacturer by the ASC. Provider billing shall include a certification that the amount sought represents its actual cost (net amount, exclusive of rebates and discounts). That certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual costs to the best of my knowledge." Review of the submitted documentation finds that the provider failed to provide certification for HCPCS Codes L8680 x 2, L8689 and L8681 in accordance with 28 TAC Section 134.402(e)(4).

2. 28 Tex. Admin. Code §134.1 applies to HCPCS Code E1399, miscellaneous durable medical equipment. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." No documentation was found requestor to support that the payment amount being sought for E1399 is a fair and reasonable rate of reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

[redacted]	[redacted]	5/19/10
Signature	Auditor III Medical Fee Dispute Resolution	Date
[redacted]	[redacted]	5/19/10
Signature	Manager, Medical Fee Dispute Resolution	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**